Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 11/16/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of a Neurobehavioral Status Examination for four hours and Neuropsychological Assessment for 20 hours.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a PhD and License Psychologist.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a Neurobehavioral Status Examination for four hours and Neuropsychological Assessment for 20 hours.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant was injured on xx/xx/xx while performing her customary duties. She has been employed. The accident occurred when her ponytail became caught in a machine that ripped off her hair and scalp. She was taken to the ER where a CT scan of the head and brain indicated “No acute intracranial hemorrhage, mass or stroke.” A CT scan of the spine indicated “No acute cervical spine abnormality and scalp soft tissue edema and hemorrhage in the soft tissue injury posterior scalp.” On the same day, she underwent surgery for debridement of scalp flap 55 cm, advancement of scalp fasciocutaneous flap 30x40 cm, and venous anastomosis for supercharging outflow of scalp flaps; complex wound closure 55 cm and SPY angiography of scalp flap. The plastic surgeon described the injury as a “near complete avulsion injury including the

forehead to the level of the eyebrows and nasal root, the right temporal region just superior to the right ear and travelling along the right later portion of the occiput. The left side of the laceration extended down the left cheek."

Current symptoms include pain of the scalp and face, numbness and weakness in her hands, and foot pain in the area of the skin graft. Average pain level is 8/10 with the lowest pain level being a 6/10. She reports significant interference with ability to conduct ADLs, ability to work, and ability to engage in recreational/social/family activities. She also reports visual disturbance, dizziness and breathlessness when turning or standing up rapidly, and fainting spells. She has been treated with medications and surgery

The claimant denies a previous history of mental health treatment. She also denies current or past use of illicit substances and does not drink. She has a second grade education and cannot read or write. Current psychological symptoms include depressed mood, bouts of crying, guilt feelings, excessive worrying, feeling unattractive, diminished self-esteem, insomnia, nightmares, decreased appetite and weight, irritability, anhedonia, and fatigue. Cognitively she reports symptoms of distractibility, diminished concentration, and memory loss, difficulty making decisions, slowed thinking, and difficulty getting organized.

She participated in an Initial Behavioral Medicine Assessment. Psychological screenings suggested severe depressive and anxiety symptoms, and the presence of some symptoms of PTSD but not enough to make a diagnosis of PTSD. On the Neurobehavioral Symptom Inventory, the claimant endorsed headaches, nausea, vision problems, hearing difficulties out of left ear, dizziness, sensitivity to noise, numbness or tingling on parts of the body, loss of appetite, poor concentration, easily distracted, forgetfulness, can't remember things, difficulty making decision, slowed thinking, difficulty getting organized, can't finish things, fatigue, loss of energy, tire easily, insomnia, difficulties falling asleep, feeling anxious, feeling depressed, irritability, and feeling easily overwhelmed. She endorsed the following symptoms of the Neuropsychological Symptom Checklist: blurred vision, numbness, tingling in the skin, pins and needles, pain, headaches, fainting spells, memory problems, can't think as easily as before, finding it hard to think clearly, being more easily distracted, and difficulty concentration. She was diagnosed with a Major Depressive Disorder, Single Episode, Severe with Anxious Distress with a rule out diagnosis of Unspecified Neurocognitive Disorder.

An Initial Rehab Evaluation indicates that the claimant was prescribed Fluoxetine hcl 20MG one QD, Tramadol hcl 50MG one CID, and Trazadone 150MG one QHS pm. She was recommended for rehabilitation training to increase strength, to be able to perform ADLs without pain, to be independent with home exercise program, and to have normal mobility.

A request for four units of Neurobehavioral Status Examination and 20 hours of Neuropsychological Assessment was submitted and subsequently denied by, PhD on agreed to the medical necessity of the request but stated that "the requested 20 hours would be excessive." A reconsideration request was denied by, PhD on after speaking with a "Delegated Designee." stated "the request is excessive and not individualized to the specific needs of the patient." On, could not support how he meets qualifications under the Texas Administrative Code, Chapter 180 – Texas Department of Insurance, 28 Monitoring and Enforcement (28 TAC 180.1(4)) because he is not trained as a neuropsychologist. further opined that was not qualified to conduct the peer review.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The claimant reports significant cognitive changes and difficulties as a result of a near complete avulsion injury to the scalp. Since the injury, the claimant reports experiencing several neuropsychological symptoms including dizziness, headaches, visual problems, sleep disturbance, concentration problems, memory problems, organizational difficulties, emotional sensitivity, depressed and anxious mood, irritability, forgetfulness, distractibility and difficulties "thinking clearly." She is diagnosed with a Major Depressive Disorder, Single Episode, Severe and a rule out diagnosis of an Unspecified Neurocognitive Disorder. Four hours of a Neurobehavioral Status Examination and 20 hours of Neuropsychological Assessment is requested to determine diagnosis, propose a treatment plan and to assess for potential malingering. The hours requested include the time to administer, score and interpret the testing. The neuropsychological battery will include tests of intellectual functioning and memory, multiple symptom validity tests, and the Meyers Neuropsychological Battery (MNB). The MNB takes over 10 hours to administer, score and interpret.

The current Head Chapter of the Official Disability Guidelines (ODG) updated 07/24/2015, subheading Neuropsychological Testing, states that testing is "Recommended for severe traumatic brain injury, but not for concussions unless symptoms persist beyond 30 days. For concussion/ mild traumatic brain injury, comprehensive neuropsychological/cognitive testing is not recommended during the first 30 days post injury, but should symptoms persist beyond 30 days, testing would be appropriate. Neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under controlled conditions, and findings interpreted by trained clinicians. Moderate and severe TBI are often associated with objective evidence of brain injury on brain scan or neurological examination (e.g., neurological deficits) and objective deficits on neuropsychological testing, whereas these evaluations are frequently not definitive in persons with concussion/mTBI. There is inadequate/insufficient evidence to determine whether an association exists between mild TBI and neurocognitive deficits and long-term adverse social functioning, including unemployment, diminished social relationships, and decrease in the ability to live

independently. Attention, memory, and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. Neuropsychological testing is one of the cornerstones of concussion and traumatic brain injury evaluation and contributes significantly to both understanding of the injury and management of the individual. The computer-based programs Immediate Post concussion Assessment and Cognitive Testing (ImPACT), CogSport, Automated Neuropsychological Assessment Metrics (ANAM), Sports Medicine Battery, and HeadMinder may have advantages over paper-and-pencil neuropsychological tests such as the McGill Abbreviated Concussion Evaluation (ACE) and the Standardized Assessment of Concussion (SAC). The application of neuropsychological (NP) testing in concussion has been shown to be of clinical value and contributes significant information in concussion evaluation, but NP assessment should not be the sole basis of management decisions. Formal NP testing is not required for all athletes, but when it is considered necessary, it should be performed by a trained neuropsychologist. Baseline NP testing is not required as an aspect of every assessment, but it may be helpful to add useful information to the overall interpretation of the tests. Persistent symptoms (>10 days) are generally reported in 10–15% of concussions, at which point investigations may include formal neuropsychological testing and conventional neuroimaging to exclude structural pathology. In cases of multiple concussions/ persistent impairment, professional athletes should be referred for neurologic and neuropsychological assessment, and amateur athletes should have formal neurologic/ cognitive assessment and risk factor counseling."

The request for four hours of neurobehavioral examination and 20 hours of neuropsychological assessment is reasonable and necessary given the tests to be administered and the time needed to administer, score and interpret the tests. The request meets current ODG guidelines for approval at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**